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Patients' perceptions of risky developments during psychotherapy

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Taking findings of patient's perceptions that psychotherapy treatment has negative side effects seriously.

Findings of patient's perceptions that psychotherapy treatment has negative side effects should not be ignored.

Short title:

Unwanted effects of psychotherapeutic treatment

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Key words:

Psychotherapy research, Psychotherapeutic damages, Psychotherapy risks, Side effects of psychotherapy, Online research, Patient information

Abstract:

Research on risks and unwanted effects is largely missing in psychotherapy. Using exploratory factor analysis (EFA) six dimensions of personal therapy situation were identified in a preliminary study, three of them were associated with risky developments during the psychotherapeutic process: (1) (poor) quality of therapeutic relationship, (2) burden caused by psychotherapy, and (3) dependency/isolation. Based on the finding of this study an online survey was performed to examine these three dimensions. Aside from these three factors another variable was associated with risky therapy developments: the online questionnaire also asked for premature terminations of psychotherapy as a consequence of risky conditions for the therapeutic development.

Risky conditions were found to be associated with the following variables: (1) the combination of female patient - male therapist, (2) the therapeutic orientation (particularly with the psychodynamic approaches) and (3) the duration of therapy. Fewer humanistic and systemic psychotherapies were found among the high risk-prone group of patients who were at risk in at least three of the four variables which were associated with risky developments. Differences in the findings of the study regarding the four therapeutic orientations stress the importance of an extensive differential indication and a cooperative partnership between patient and therapist, in order to facilitate a positive patient participation towards the choice of therapy method and subsequent successful participation throughout the course of treatment. Further studies should also focus on female patient and male therapist psychotherapies.

Key words:

Psychotherapy research, Psychotherapeutic damages, Psychotherapy risks, conditions for negative development, online research, side effects

Introduction

A vast amount of narrative reports on risks and side effects of psychotherapy exist in the literature, yet there is little empirical data. Bergin already observed in 1963 that approximately 10% of patients felt worse after receiving psychotherapy (1963), a fact that was replicated in more recent studies (Beutler et al. 2004). Jacobi (2002) noted that up until the 1980's the possibility of negative developments were not even a consideration in psychotherapy research. Busch and Lemme (1992) observed in a study of psychotherapists, from a variety of psychotherapeutic approaches who had been practising for an average of 10 years, that nearly 70% of the sample opposed the idea of side effects in psychotherapy. Ten years later Frohburg (2001) suggested a developing acceptance of the concept of possible side effects in psychotherapy.

How can effects, risks and side effects of psychotherapy be operationalized? Strupp, Fox and Lessner (1969) developed a multi-factorial view of psychotherapy outcomes from a patient perspective. This approach was later supported by Elliott (1991). Connolly and Strupp (1996) concluded that according to current research patient perspective outcome should be captured by the dimensions of symptom relief and changes in self-concept. In contrast, more recent studies advocated for a much broader view (Rennie 2000; Orlinsky et al. 2004; Hill and Lambert 2004; Levitt et al. 2006; Binder et al. 2010). In particular Levitt, Butler and Hill (2006), as well as Binder, Holgerson and Nielsen (2010) argued for a patient perspective that downplays symptom relief but instead includes further aspects of life satisfaction.

Clearly, an empirical systematization of unwanted effects in psychotherapy has yet to be established. A review of the literature on psychotherapy outcome research produced only a few papers focusing specifically on deterioration or side effects (Kraus et al. 2011; Barlow 2010; Hatfield et al. 2009; Lambert 2004; Nolan et al. 2004; Strupp et al. 1977). Heins et al. stimulated a discourse on unwanted effects through the publication of their recent study in which symptom deterioration in cognitive-behavioral therapy (CBT) was systematically investigated by chronic fatigue syndrome patients (Heins et al. 2010; Kindlon 2011; Heins et al. 2011). In summary, it can be assumed that because of the central role of interpersonal interaction, psychotherapy will always include an element of risk for

the patient as well as the therapist (Lambert and Barley 2002) . The therapeutic relationship is mentioned by many authors as one of the most important predictor of a successful psychotherapy (Grawe 2005; Hermer and Röhrle 2008b; Strauß and Wittmann 2005; Horvath and Symonds 1991). Horvarth und Symonds (1991) concluded that the correlation between therapeutic relationship and treatment success was the highest when the relationship was being assessed by the patient as compared to the therapist or external observers. Märtens, Liegl and Leitner (2012, in prep.) showed that aside from the importance of the assessed therapeutic relationship for therapeutic success, negatively experienced therapeutic relationship contributes to a decline in life satisfaction during the course of the therapy. This leads to the assumption that patients who experience the therapeutic relationship quality as under average are more likely to experience negative therapy outcomes.

Aside from a poor therapeutic relationship, a high level of dependence towards the therapist can be seen as a risky condition for a negative therapy development. It can be assumed that negative effects occur more likely and are more severe, the more the patients feel depended on the therapist. Märtens, Liegl und Leitner (2012, in prep.) showed that particularly patients experiencing an incline in life satisfaction during their therapy stay especially long in therapy. This result can be possibly explained by an overly strong dependency that prevents the patient to terminate the therapy by themselves.

Recent findings suggest that therapists often do not register deteriorations adequately. In a study on self-evaluation (Lambert 2010) about half of the therapist surveyed reported that their own patients never experienced deterioration. The results of Hannan et al. (2005) coincide that in fact only 20% of therapists notice the experienced deterioration of their patients. It seems probable that negative effects of such lack of perception by therapist can be severely increased (made worse) by a patient's overly strong sense of dependency towards the therapist.

An ongoing therapy can lead to burden for patients in different ways. Aside from side effects like symptom deterioration and decreasing life satisfaction, psychotherapy can cause burdens and fears in connection to the therapy, such as fear of unwanted changes in the social environment or the fear of disappointing the therapist through the own behavior. These kinds of burden do not necessarily constitute a negative therapy development and are to a certain degree not unusual in critical phases of

therapy. When the therapy is perceived as above average burdening over a longer period of time though, it could negatively influence the symptomatology.

It has to be differentiated how unwanted effects were pertained. Hoffman et al. (2008) distinguished between (1) side effects of an adequate therapy, (2) side effects due to unprofessional practice of treatment, (3) lacking fit between the personality of the therapist with the personality of the patient and (4) damages caused by unethical conduct of the therapist.

The present study didn't focus on measuring negative effects of psychotherapy directly. In a first step we searched specifically for conditions of the psychotherapeutic process that make unwanted effects more likely. Three dimensions were identified by factor analysis that can be associated with risky developments during the psychotherapeutic process: (1) perceived quality of therapeutic relationship; (2) burdened by psychotherapy; (3) dependency/isolation.

Aside from these three factor-analytically identified risky conditions (4) *the premature termination of psychotherapy* was associated with risky therapy developments.

In a second step we examined which variables of the therapeutic setting might influence such risky conditions, thus showing the importance of the influence of (1) therapeutic orientation, (2) gender combination between therapist and patient, and (3) duration of therapy. The corresponding detailed results are presented in this paper.

Methods

The study met the requirements of the Data Protection Act 2000 "for the purpose of scientific or statistical research"(BGB1.I). The General Assembly of the Austrian Psychotherapy Advisory Board of the Federal Ministry of Health was informed, as well as the Appeal and Research Committee of the Psychotherapy Committee of the Federal Ministry, who particularly welcomed the investigation. This study was conducted in accordance with the current rules and standards of online surveys and comparable studies(Birnbaum 2004; Gosling et al. 2004) , that is, no personal data or information that could lead to the identification of a specific individual was collected.

Construction of the questionnaire

The initial exploration phase entailed data from seven focus group discussions with two to five experienced psychotherapists who are also engaged in training psychotherapy students and patient complaints. The focus groups were conducted to explore the field of interest, examine the experience of psychotherapists, and to identify possible causes of risks, adverse effects and damages. A total of 29 experts - 16 (55,2%) women and 13 (44,8%) men - participated, including at least one representative from each of the 21 psychotherapeutic approaches accredited in Austria. The focus group interviews were started with an open introduction question. They were asked about their individual work experience with side effects or damages in psychotherapy, implying that they might have heard about cases from peers or dealt with patients coming from previous risky developments. The interviewer asked to be very precise in the description of these developments. This invoked lively discussions among the groups. The interviewer introduced a set of follow up questions regarding indicators of side effects, cases of misconduct, negative development of psychotherapeutic process and therapist variables in case they were not covered in the course of the discussion. This resulted in 7 group interviews from 1,5 to 2 hours length adding up to 377 pages of transcripts.

In a second explorative part 42 anonymized copies of original complaints written to individual ethics commissions for psychotherapy of the 9 Austrian federal states in the time from 1999 to 2007 were analyzed. These letters came from severe cases that could not be regionally solved and therefore were presented to the complaints board of the Austrian federal ministry of health. No additional case information was included in the data. The hermeneutic unit covered 182 pages of material.

The group discussions were analyzed using the grounded theory techniques described by Anselm Strauss (1987) as open and selective coding in order to generate thematic categories that are grounded in the data. These thematic categories were represented within case reconstructions. In a parallel process the complaints were analyzed following Mayring's steps (2000) of summarizing content analysis leading to thematic categories. This method was chosen due to the highly sensitive information within the data. After multiple discussions the research team chose main and sub

categories by merging both data units. This resulted in 14 main and 42 subcategories. This process was recorded within memos.

In the next step 5-6 questions were phrased for covering each category mostly using quotes from both data sets. The research team selected 200 of these items for the draft of the questionnaire by repeatedly returning to the data in an endpoint of the analytic process. As a result of multiple research conferences with external research advisers the essential 61 items were chosen for the questionnaire. About ¼ of these originated from the focus discussions and ¾ from the complaint letters. As an external assessment this final questionnaire was given to 70 peers of psychotherapists who filled it out and gave comments, which were incorporated into the final version of this explorative instrument. These 61 statement items were assessed by the respondents using a 5-point Likert scale (from 1 = "disagree" to 5 = "strongly agree") with respect to the particular individual therapy situation. Supported by the Lower Austrian Health department, the Social Fund (NÖGUS), and the regional state insurer (NÖGKK) the explorative questionnaire was sent to all 1676 patients that had received a reimbursement in the second quarter of 2008. 552 (32.9%) completed questionnaires were returned.

Based on the 61 statements about the personal therapy situation, the following six factors (accounting for 41.6% of the total variance) were determined via orthogonal factor analysis (Varimax with Kaiser Normalization, Scree-test to identify the number of factors):

- "Perceived quality of therapeutic relationship" (accounting for 18.8% of the total variance): 22 items loaded on this factor, which can be viewed as a measure of how comfortable the patient feels in the relationship with the therapist.
- "Positive effect" (accounting for 7.1% of the total variance): This factor could be assigned to seven items that gave information about positive changes in the lives of patients in the course of psychotherapy.
- "Emotional sensitivity" (accounting for 4.8% of the total variance): Eight items could be assigned to this factor which is a measure of changes in emotional sensitivity.

- "Burden caused by psychotherapy" (accounting for 4.2% of the total variance): Nine items loaded on this factor providing information about patient fears and overburden tendencies in connection with psychotherapy.
- "Dependency/Isolation" (accounting for 3.6% of the total variance): Ten items were listed under this factor which provides information as to whether the patient developed a high degree of dependence towards the therapist in the course of therapy while experiencing inadequate social support outside of therapy.
- "Educational information about possible changes" (accounting for 3.1% of the total variance): This factor included five items that provide information as to whether the patients are informed about the possibility of (unexpected and burdening) changes in the course of psychotherapy.

To shorten the exploratory questionnaire in order to achieve maximum participation in the subsequent online survey, not all of the mentioned items describing the underlying factors were chosen. First, we excluded all of the items regarding to the factor "Educational information about possible changes". The necessary number of the highest loading items of each of the remaining five factors were chosen so that the means of these items correlated at least by r = .75 with the means of all original items. By doing so, three to four original items per factor were accepted for the final version of the questionnaire. In this final online questionnaire with its five factors (accounting for 73.4% of total variance), the following three factors were associated with risky developments:

(1) *Perceived quality of the therapeutic relationship* (accounting for 21.6% of the total variance, Cronbach's Alpha = .94), measured by the following statements: "I was satisfied with my therapist", "I feel that my therapist understands me", "I could trust my therapist and "My therapist takes my seriously".

(2) *Dependency/Isolation* (accounting for 10% of the total variance, Cronbach's Alpha = .56), measured by the following statements: "I feel that my therapist is the most important person in my life", "I feel that my therapist is the only person that listens to me" and "I do not get help and support from my social network beyond the psychotherapy".

(3) *Burden caused by psychotherapy* (accounting for 8% of the total variance, Cronbach's Alpha = .64), measured by the following statements: "I feel overwhelmed in therapy", "I'd be afraid of the reaction of my therapist, if I would tell him/her that I want to end the therapy" and "I'm afraid someone could notice that I'm in psychotherapy".

Aside from these statements that were used for the factor analysis the online questionnaire also asked for other information, for example for the gender of therapist and patient, the therapeutic orientation, the duration of the therapy and – if the therapy had already ended – whether the therapy had been successful or terminated prematurely.

Procedure

From October 2009 through April 2010, the final version of the questionnaire was accessible online and was promoted in Austrian daily newspapers, online magazines and via Google.at. The attached instructional text explicitly addressed adults who were currently experiencing or had experienced psychotherapy as a patient in Austria and were willing to report.

In addition to answers from under 18-year-olds (six respondents), all questionnaires that were only partially completed (1376 questionnaires), and one questionnaire that had been filled out completely in less than four minutes were excluded from the analysis. Thus, after the end of the data collecting period, a total of 2056 fully completed questionnaires were available for evaluation.

Sample characteristics

1357 of completed questionnaires were submitted by women (66.0%) and 699 by men (34.0%). In regards to patient-therapist pairing, the combination female patient and female therapist was found 910 times representing the largest group (44.3%), followed by 447 pairs of female patient - male therapist settings (21.7%). In 345 cases (16.8%) the patients were male with a female therapist, and in 354 pairs (17.2%) both, patient and therapist, were male. A subsample of 1504 patients (73.2%) were able to name the therapeutic orientation they were or had been treated with. 593 (39.4% of the subsample) could be counted to the humanistic orientation (Perls, Rogers, Moreno, Frankl…), 573

(38.1%) towards psychodynamic orientation (Freud, Jung, Adler…), 200 (13.3%) to the systemic (family therapy, couples therapy), and 138 (9.2%) towards the cognitive-behavioral orientation (CBT). A total of 1309 respondents (63.7% of the total sample) had terminated psychotherapy at the time of the online survey.

Data analysis

Each factor's outcome was calculated through the means of the according items (with a minimum of mean = 1 and a maximum of mean = 5). Patients showing a mean > 3 for the factors burden or dependency/isolation or a mean < 3 for the factor therapeutic relationship were viewed as „risk-prone patients", as well as patients that ended their therapy prematurely. For each conditions the percentage of gender combinations and the percentage of therapeutic orientations in the subgroup of those patients who showed risk-prone ratings ("observed percentage") were compared with the percentage in the subsample of those patients showing no abnormalities in the appropriate condition ("expected percentage").

The perceived quality of therapeutic relationship, therapy induced burden, therapy related dependency/isolation as well as the premature termination of therapy were also related to the *treatment dosage* for each of the four therapeutic orientations. Treatment dosage was determined by multiplying the duration of therapy in months with the average number of therapy sessions that had been completed by the particular patient each month. This resulted in an approximate value, which corresponded to the absolute number of sessions of a patient.

Additionally, patients who were at risk in at least three of the four dimensions were defined as "high risk-prone group". These highly burdened patients ("observed percentage") were compared to those experiencing no negative development ("expected percentage") in any area, again in regards to therapeutic orientation and gender combination.

Comparisons between observed and expected percentage were examined by Pearsons chi-squared tests. Since, according to the results of the Kolmogorov-Smirnov test, the data was not normally distributed, associations between two variables were calculated using Spearman's rank-correlations. For mean comparisons between independent variables the Mann-Whitney U-test for independent samples was chosen. For mean comparisons between more than two independent variables Kruskal-Wallis test was administered. The significance level was set conventionally at $\alpha = .05$, two-tailed.

Results

Therapeutic relationship quality

Four hundred and fifty-nine patients (22.3%) perceived their therapeutic relationship as poor. In this group, the observed percentage of patients in humanistic psychotherapies was significantly lower than expected, while the observed percentage of patients in CBT and in psychodynamic treatments was significantly higher than expected (see Figure 1, subsample n = 1504).

The combination male therapist - female patient was significantly more frequent in patients who perceived their therapeutic relationship as poor (132 of 459 patients; 28.8 %), as compared to patients with a satisfactory therapeutic relationship (315 of 1597 patients; 19.7%, $p < .001$).

Burden caused by therapy

Two hundred and sixty-seven patients (13.0% of the total sample) indicated high levels of burden caused by therapy. In this group, the observed percentage of patients in both humanistic and systemic psychotherapies were significantly lower than expected, while the observed percentage of patients in psychodynamic treatments was significantly higher than expected (see Figure 2, subsample n = 1504).

The gender combination male therapist - female patient was found significantly more frequent among those burdened by therapy (83 of 267 patients; 31.1%) than in those with a low burden (364 of 1789 patients; 20.3%, $p < .001$).

Dependency/Isolation

A total of 367 patients (17.9% of the total sample) felt highly dependent/isolated. In this group, the observed percentage of patients in both humanistic and systemic psychotherapies were significantly lower than expected, while the observed percentage of patients in psychodynamic treatments was significantly higher than expected (see Figure 3, subsample n = 1504).

Again, the combination male therapist - female patient was found significantly more frequent among the highly isolated patients (109 of 367 patients; 29.7%) than in those with a low level of dependency/isolation (338 of 1689 patients; 20.0%, $p < .001$).

Premature termination of therapy

A total of 1309 respondents (63.7% of the total sample) had terminated psychotherapy at the time of the online survey. Of these, 416 (31.8%) had ended their therapy prematurely. In this group, the observed percentage of patients in humanistic psychotherapies was significantly lower than expected, while the observed percentage of patients in psychodynamic treatments was significantly higher than expected (see Figure 4, subsample n = 842).

The combination male therapist - female patient was found significantly more frequent in patients who ended their therapies prematurely (118 of 416 patients; 28.4%) than in successful psychotherapy completers (144 of 735 patients; 19.6%, $p < .001$). In comparison, the combination female therapist - female patient was found significantly less frequent in patients who ended their therapies prematurely (156 of 416 patients; 37.5%) than in successful completers (333 of 735 patients; 45.3%, $p < .05$).

Treatment dosage

The number of therapy sessions in psychodynamic treatments (median = 120, interquartile range = 260) was significantly higher than in humanistic (median = 56, interquartile range = 120, $p < .001$), systemic (median = 28, interquartile range = 36, $p < .001$), and cognitive-behavioral psychotherapies (median = 48, interquartile range = 76, $p < .001$). The number of completed therapy sessions in

systemic psychotherapy was significantly lower than in humanistic ($p < .001$) and in cognitive-behavioral therapies ($p < .01$).

In psychodynamic psychotherapies, the number of treatment sessions correlated significantly with the perceived burden caused by therapy ($r_s = .22$, $p < .01$) and the perceived dependency/isolation ($r_s = .24$, $p < .01$, see Table 1).

Patients under psychodynamic psychotherapy who ended the treatment prematurely had significantly more therapy sessions (mean rank = 166) than those who had successfully completed their treatment (mean rank= 145, $p < .05$). In the humanistic psychotherapies, the number of treatment sessions correlated significantly with dependency/isolation ($r_s = .22$, $p < .01$) and with the perceived quality of the therapeutic relationship ($r_s = .18$, $p < .01$). In this group though, patients who terminated the therapy prematurely had significantly fewer therapy sessions (mean rank = 145) than the treatment completers (mean rank = 170, $p < .05$). In systemic therapies, the treatment dosage correlated significantly with burden caused by therapy ($r_s = .24$, $p < .01$). In systemic therapies, patients who terminated the psychotherapy prematurely, reported significantly fewer therapy sessions (mean rank = 54) as compared to completers (mean rank = 69, $p < .05$). Finally, in cognitive-behavioral therapies, the number of treatment sessions correlated significantly with burden caused by therapy ($r_s = .24$, $p < .05$). No significant differences in treatment dosage were found between patients who terminated prematurely and completers in the CBT group.

High risk-prone group

One hundred and sixty-six patients (8.1%) were at risk in at least three of the four dimensions (poor quality of therapeutic relationship, burden, dependency/isolation, and premature termination), while 1188 patients (57.8%) could not be assigned to any risk group. Significantly less humanistic and systemic, and significantly more psychodynamic psychotherapies were observed in the 166 high risk-prone patients, as compared to the 1188 patients (expected) with no risk (see Figure 5).

The combination male therapist - female patient was found significantly more frequently within the high risk-prone group of patients (69 of 166 patients; 41.6%) than in those who were in no risk group (224 of 1188 patients; 18.9%, $p < .001$). Significantly fewer pairs of female therapist - male patient were found among the high risk-prone group of patients (15 of 166 patients; 9.0%) than in those who were in no risk group (196 of 1188 patients; 16.5%, $p < .01$).

Discussion

The majority of patients reported of positive therapy conditions, according to the results of empirical studies that demonstrate that psychotherapy is effective. However, this study also demonstrates that psychotherapy can also come along with risky conditions. Female patients treated by a male therapist seem to be exposed to a higher risk of negative developments during psychotherapy. This group reported above average of a less satisfactory therapeutic relationship and experienced more frequent periods of dependency/isolation and higher levels of burden caused by therapy. Women in therapy with male therapists ended their therapy prematurely above average in contrast to women with female therapists. Also, within the high risk-prone group of patients, women with male therapists were found above average and men with female therapists considerably less. These gender combination results are consistent with gender research in psychotherapy(Neises and Barolin 2009) , showing that specific issues are more difficult or respectively easier to work with, in each therapist-patient gender constellation. In contrast, Beutler et al.(2004) stated in the Handbook of Psychotherapy and Behavior Change that the gender of the therapist hardly makes a contribution in predicting progress and premature termination (Beutler et al. 2004). The study supports the notion of providing gender-specific considerations (Nadelson et al. 2005; Sonnenmoser 2002) with choosing appropriate treatment approaches.

In addition, this study's results suggest differences in risk potentials across therapeutic orientations. Patients who experienced a poor therapeutic relationship, a high degree of dependency/isolation and burden through psychotherapy were more frequently treated in psychodynamic therapies. Regarding the psychodynamic orientations, the number of therapy sessions correlated positively with the extent of patients' treatment-related burden and dependency/isolation. Moreover, patients who ended their

therapies prematurely prevailed above average in psychodynamic therapies and were associated – in contrast to the other three psychotherapeutic approaches – with a higher number of therapy sessions. These findings as a whole suggest that patients in psychodynamic orientations frequently show negative developments, whereby the risk increases distinctly with the length of the therapy. The fact that patients of these orientations even stay in the therapy for a long time could be explained by the high proportion of patient dependency. Hoffman (2002) suggested that there is a strong indication that psychoanalysis is especially susceptible to negative effects. Fäh (2002) saw a connection to the psychoanalytical lack of dealing with possible failures in the past. Hoffman stated the "problematic logic of more of the same" meaning that psychoanalysis interprets a patient's dysfunctional behavior as destructive impulses which should be addressed by longer and more intensive treatment in accordance to psychoanalytic theory. This can lead to misinterpretation of negative developments preventing the therapist to register them. Further this can lead to an even longer damaging – non helpful - dependent relationship with the therapist. It has to be made clear that Hoffman's results only refer to psychoanalysis and very likely do not transfer to other psychodynamic orientations.
CBT patients also more frequently perceived the quality of their therapeutic relationship as poor. Treatment dosage and burden correlated significantly. Patients in CBT who terminated prematurely had attended fewer therapy sessions than those who had ended their therapy successfully. According to Jacobi (2002) failures in the CBT can be explained among other aspects by (1) an overuse of manuals which suppresses the possibility to choose a course of treatment that would fit to the individual patient, (2) translating research findings that were attained under conditions that are far from the actual work conditions. On the other hand, since patients in CBT experience low dependency to the therapist they terminate therapy faster, which can also cause damage according to Hoffman
Patients in humanistic therapy were considerably less strained in regards to the quality of their therapeutic relationship, perceived dependency/isolation, and burden through therapy. Within patients in humanistic therapy premature discontinuation of their therapy also occurred less often as well as being in the high risk-prone group. Here therapy dosage was associated with dependency/isolation but also with a satisfactory therapeutic relationship. Patients ending their therapy prematurely attended fewer therapy sessions than treatment completers. Hoffman et al. (2008) sees one reason for the

majority of positive results of humanistic orientations in the comparatively high value of detecting negative developments in an early stage in the therapeutic process.

Also, the results of systemic psychotherapies showed less perceived burden and less phases of dependency/isolation, as well as a positive relation between therapy dosage and experienced burden. Patients who terminated their psychotherapy prematurely attended fewer sessions in systemic psychotherapies. Patients of this method rarely are found in the high risk-prone group. The reasons for good results regarding burden, dependency and dependency/isolation could be directly derived to the therapeutic attitude. The systemic paradigm focuses on resource-, goal -and customer orientated attitude. The duration of a therapeutic process is mostly designed to be relatively short (up to 10 sessions).

To which degree the differences found across the therapeutic orientations can be ascribed to the therapist effect (Wampold and Brown 2005; Kim et al. 2006) and less to the method, could not be controlled due to the anonymity of the survey.

The total dosage, i.e., the intensity and duration of treatment are obviously factors that make the occurrence of adverse developments more likely. This leads to an imperative to justify long-lasting therapies and to carefully weigh the risks against the expected desired effects. This result indicates that the classic notion, that more therapy produces more gain (dose-effect-relation) should be questioned. It should be noted that treatments which depend on strong therapeutic bonds constitute a precondition for a successful therapy on the one hand, but pose the risk of unwanted effects on the other hand.

Patients' perception of dependency/isolation and burden caused by therapy seem to occur more frequently if long-term treatment is combined with a patient's perception of a poor therapeutic relationship. Thus, it remains uncertain which phenomenon can be interpreted as a cause. The question to what extent such phenomena lie in the method of the psychodynamic approach, or can be ascribed to the severity of the diagnosis, or to non-specific aspects such as length and intensity of treatment, remains a research question to be addressed. A verified conclusion would demand a comparison with other therapeutic approaches through randomized controlled trials, controlling for diagnosis, intensity and duration of treatment.

The results of Stiles et al. support the concept of "responsive regulation" (Barkham et al. 2006; Stiles et al. 2008). According to Carey, positive therapy results increase with the degree of patient's input throughout the course of their treatment (2010; 2009). Decisions regarding the optimal number of therapy sessions and the end of therapy should be more often discussed with the patient. It seems that patients know best what is good for them. This finding goes along with Barkham et al.'s (2006) conclusion that patient involvement in strategic decision's concerning the process of therapy has a positive effect on the therapy.

The present study results may indicate an insufficient patient participation in the therapeutic process. More than in other methods, in psychodynamic therapy, it seems difficult for patients to end negative treatment courses. This is highlighted by the differences in the other methods in which early treatment terminations were made more often if the treatment was not successful.

This study has a number of limitations that need to be addressed.

- It is possible that due to the design of the study, the research question and the explicit invitation to report negative experiences, an over proportional amount of patients with negative experiences were motivated to fill out the survey. The questionnaire might have been a chance to communicate about their case and to voice their criticisms. These aspects have to be taken into consideration when discussing possible distortions in occurrence probabilities. This critical observation can be countered by the fact that distortions in the other direction may be assumed when patients that end therapy prematurely are not included in the results of other studies (Frank and Fiegenbaum 1994; Lambert 2010). Additionally, it can be assumed that due to a higher expectancy of anonymity in online surveys people give honest answers (Welker et al. 2005), and socially desirable response behavior appears to be less pronounced.
- While based on the results of this study it can be established which treatment approach appears to be more risk prone than others, no reliable results of absolute frequencies of negative therapy developments within the population can be given, due to the voluntary study participation. Method specific risk comparisons can therefore not be carried out.

- A majority of respondents have already ended their therapy at the time they filled out the survey. Possible perceptual distortions in the retrospective assessment of certain therapy characteristics could not have been controlled.
- In contrast to experimental designs and face to face surveys and due to the anonymous nature of online studies it cannot be verified whether or not the responders were actually psychotherapy patients.

It has to be pointed out that none of the discussed variables determine a negative therapy development; they just seem to make the occurrence of risky conditions more probable. The majority of patients in all therapy orientations and all gender combinations could not be related to a risk-prone group. Also, therapy dosage is no predictor per se for unwanted therapy effects, since many patients with a very high amount of therapy sessions reported of positive therapy experiences.

Therefore, future research will have to specifically focus on psychotherapies with poor outcome, looking into risk factors that predict deterioration. The methodological and practical challenge here, will be to select samples that (1) represent specific groups of patients with negative therapy courses in different psychotherapeutic orientations, and that (2) are large enough to allow differential conclusions on causes and context conditions of specific deteriorations, and that (3) allow to distinguish between effects of sychotherapeutic methods and effects of psychotherapists as individual persons.

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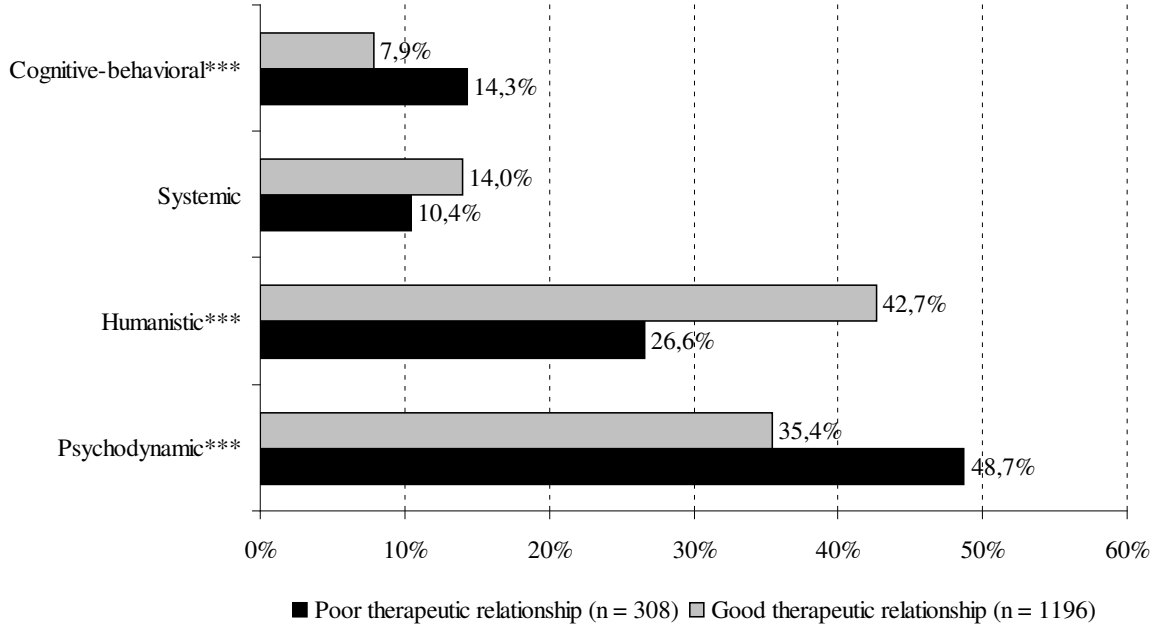
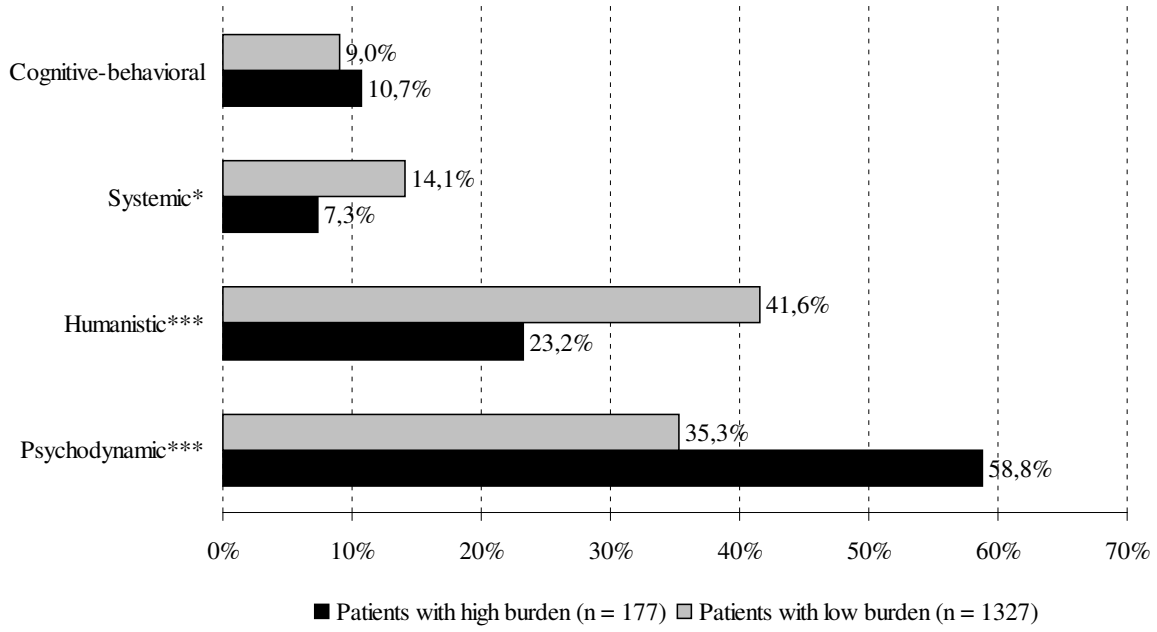
Figures and tables

Figure 1: Patients perceptions of their therapeutic relationship by therapeutic orientations



*** p < .001

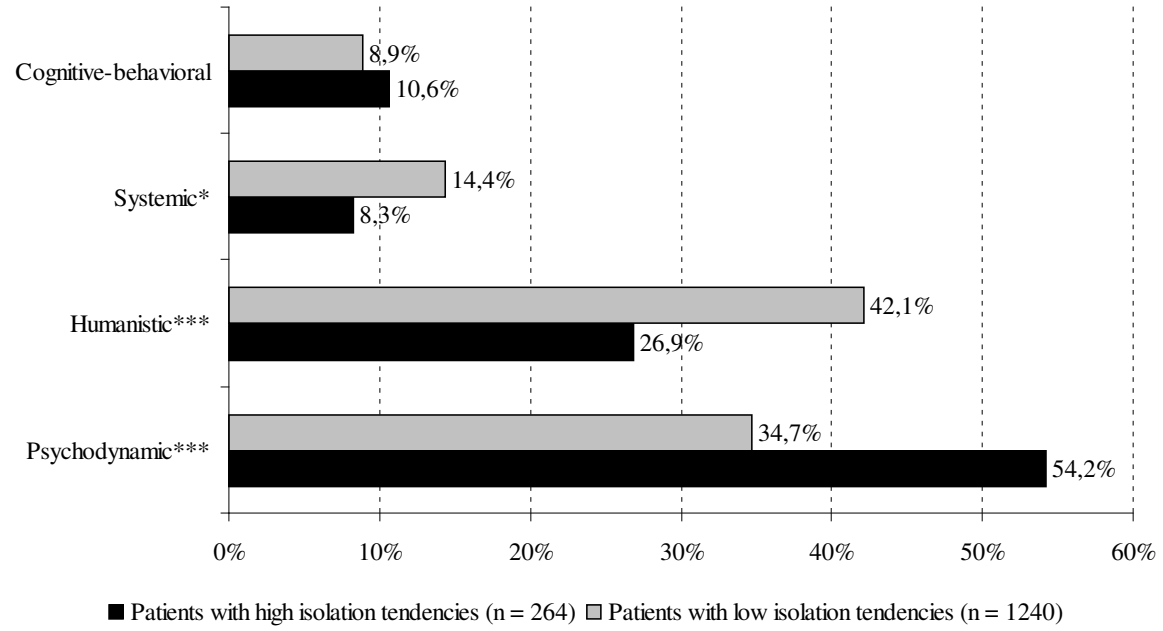
Figure 2: Level of burden caused by psychotherapy by therapeutic orientations



* p < .05

*** p < .001

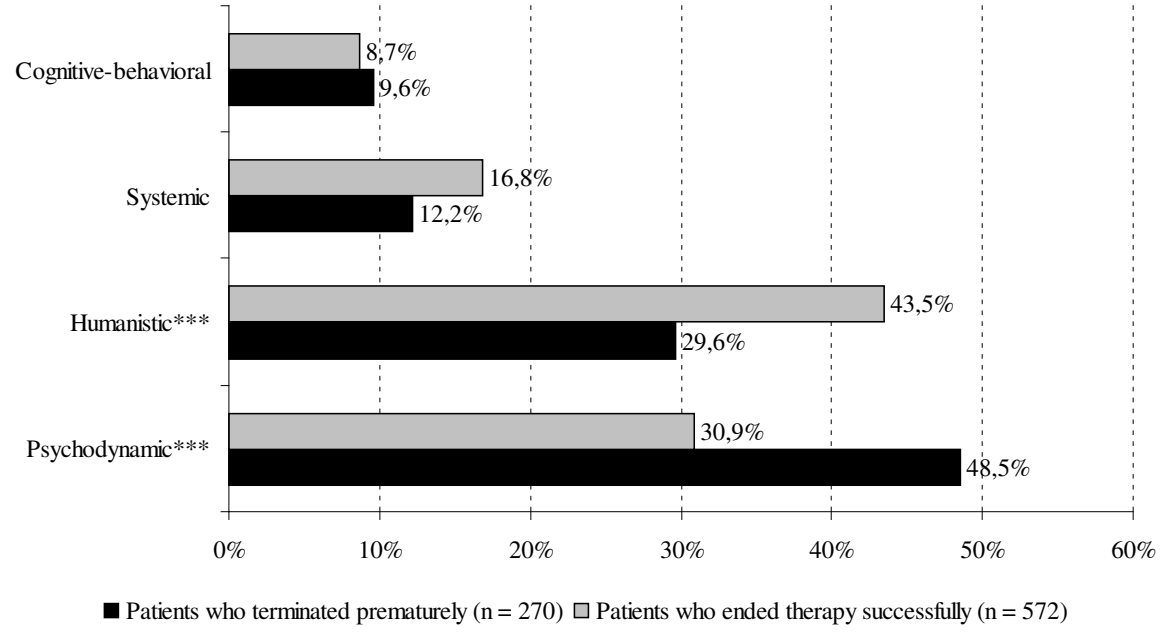
Figure 3: Isolation by therapeutic orientations



* p < .05

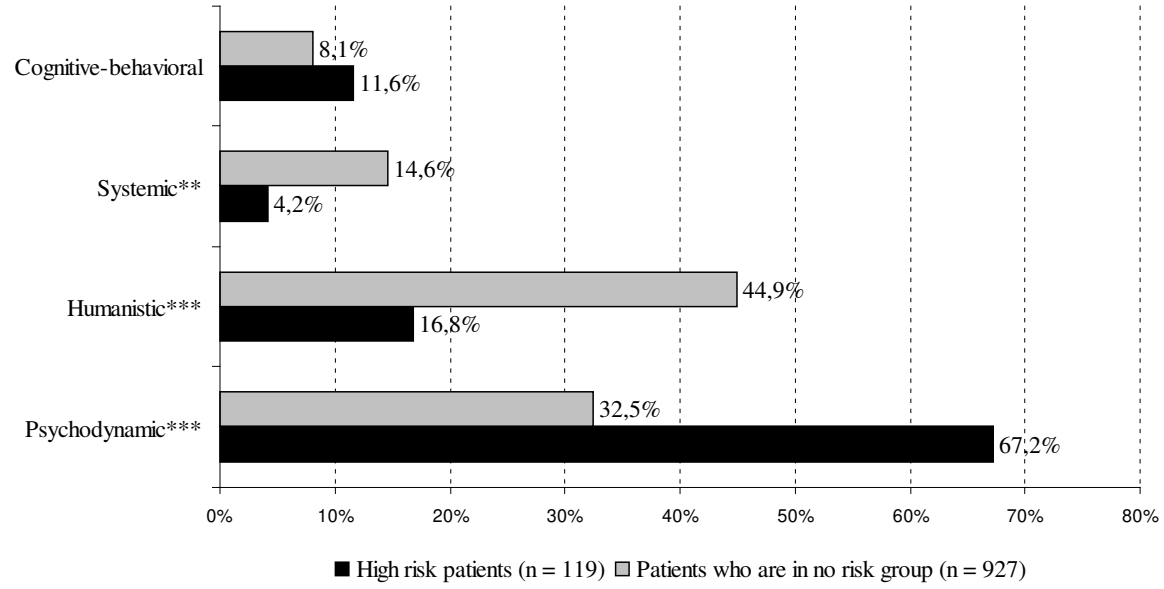
*** p < .001

Figure 4: Patients who terminated their therapy prematurely and treatment completers by therapeutic orientations



*** p < .001

Figure 5**:** High risk and “no risk” patients by therapeutic orientations



** p < .01

*** p < .001

Table 1: Correlations (Spearman's r_s) between therapy dosage and the dimensions therapeutic relationship, burden and isolation by treatment orientations

Therapeutic orientation		Therapy dosage	Quality of relationship	Burden	Isolation
Psychodynamic	Therapy dosage				
	Quality of relationship	-.08			
	Burden	.22**	-.63**		
	Isolation	.24**	-.19*	.34**	
Humanistic	Therapy dosage				
	Quality of relationship	.18**			
	Burden	.02	-.42**		
	Isolation	.22**	.09	.23**	
Systemic	Therapy dosage				
	Quality of relationship	.08			
	Burden	.24**	-.33**		
	Isolation	.06	.11	.21*	
Cognitive-behavioral	Therapy dosage				
	Quality of relationship	.06			
	Burden	.24*	-.56**		
	Isolation	.14	-.07	.37**	

** p < .01 (two tailed)

* p < .05 (two tailed)